

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013520

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318 1003 3280

FILED MAR 28 1963

VS-300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in lb 3yrs126dys		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital		d. STREET ADDRESS (If outside, give location) 5800 Arsenal Street	
3. NAME OF DECEASED (Type or print) First Middle Last Elba May Letford		4. DATE OF DEATH Month Day Year March 10, 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOW N		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William McClure		13b. MOTHER'S MAIDEN NAME Sallie McClure	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (If yes, give war or dates)	
16. INFORMANT N		17. ADDRESS Chronic Hospital Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4yrs DUE TO (b) _____ DUE TO (c) 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. Obesity 2. Chronic Pyelonephritis PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11-4-59 to 3-10-63 and last saw her alive on 3-10-63 Death occurred at 5:15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) Kenneth C. Price MD		22b. ADDRESS 5600 Arsenal	
22c. DATE SIGNED 3/11/63		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried at Baker Mortuary Service		23b. DATE 3-31-63	
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. FUNERAL HOME OR SERVICE 4104 Manchester Ave.		25. DATE RECD. BY LOCAL REG. MAR 21 1963	
26. REGISTRAR'S SIGNATURE Road Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.